Minnesota BOARD OF Nursing

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Website: www.nursingboard.state.mn.us

CONFIRMATION OF PROGRAM COMPLETION - ADVANCED PRACTICE REGISTERED NURSE

The information and evidence you are asked to provide on this application is authorized by Minnesota Statutes and will be used to determine your eligibility and/or qualifications for the license for which you are applying; enable us to contact you when necessary; identify you and comply with certain federal and state reporting requirements.

Until you are licensed, all data submitted on this form, except your name and address, are considered private data and will not be released to anyone other than Board of Nursing staff and its agents. When you become licensed, all data submitted on the form become public record. Some or all of the data may be given to the Commissioner of Revenue, the Legislative Auditor, in response to a court order, or others in accordance with statutes, rules and professional standards.

You are legally required to submit true and complete information. Furnishing the requested information means the information may be provided to parties listed above. Refusal to supply information may result in denial of a license. Falsification or omission of information may be used by the Board as a basis for disciplinary action.

•Type or print clearly•Use black ink •Provide all information •Incomplete applications will be returned •Do not use initials or abbreviations

APPLICANT INFORMATION

Complete the applicant information. If you do not have a graduate education as an APRN in one of the four roles and one of the six population foci, check the appropriate box and verify that you were recognized by the Minnesota Board of Nursing to practice as an APRN on July 1, 2014. This means that the Board had a current copy of your certification as an APRN. If you do not have a graduate level education and you were not recognized by the Board of Nursing to practice as an APRN on July 1, 2014, you are not eligible for licensure as an APRN in Minnesota. Sign and date the document. The *Affidavit Section* is to be completed by the school official of the APRN program you attended. Mail the document to the appropriate APRN program.

LAST NAME	FIRST NAME	MIDDLE NAME ☐ No middle name
MAIDEN NAME	OTHER LAST NAME(S)	PHONE NUMBER ☐ Home ☐ Business ( )
MINNESOTA LICENSE NUMBER ☐ RN _____		BIRTH DATE (mm/dd/yyyy)
APRN PROGRAM NAME (no initials)		
CITY AND STATE OF APRN PROGRAM		COMPLETION DATE (mm/dd/yyyy)

☐ I authorize _____(name of APRN program) to release my educational dates to the Minnesota Board of Nursing.

☐ I do not meet the requirements for completion of graduate level education as an APRN in one of the four APRN roles and population focus.
☐ I was recognized by the Board to practice as an APRN prior to and on July 1, 2014.

_____ _____
Legal Signature Date (mm/dd/yyyy)

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Applicant: Complete the *Applicant Information* section above and forward to your school of nursing for completion. If the school official is not able to verify completion of all requirements, contact the Board of Nursing for further instructions.

School Official: Complete *Affidavit* section below.

AFFIDAVIT SECTION
⬇ This Section for School Use Only - Applicant: Do Not Write Below This Line ⬇

SCHOOL OFFICIAL: Complete Affidavit Section after the above named applicant has fulfilled all the requirements of the nursing program and is eligible for graduation.

PROGRAM INFORMATION

Was the APRN program at a graduate level? YES ☐ NO ☐

ROLE PREPARATION:

☐ Nurse Practitioner ☐ Registered Nurse Anesthetist ☐ Clinical Nurse Specialist ☐ Nurse Midwife

POPULATION FOCUS:

☐ Adult-Gerontology ☐ Family and Individual ☐ Neonatal ☐ Pediatric ☐ Women's and Gender Health

☐ Psychiatric and Mental Health

☐ Acute (if applicable) ☐ Primary (if applicable)

Is the program accredited by a national nursing accrediting agency? YES ☐ NO ☐

Is approval of the nursing program required by the Board of Nursing? YES ☐ NO ☐

Name of the Board of Nursing granting program approval _____

NAME OF ACCREDITATION BODY	DATES OF CURRENT ACCREDITATION (mm/dd/yyyy-mm/dd/yyyy)
DEGREE TYPE ☐ Doctorate of Nursing Practice ☐ Masters ☐ Other (explain) _____	COMPLETION DATE (mm/dd/yyyy)

The undersigned does hereby affirm that the information provided is true and correct.

_____
Signature of School Official

_____ Affix School Seal or Stamp
Name and Title (print)

Return completed form to Minnesota Board of Nursing